Family PACT: Provider Record Keeping

This section outlines Family PACT (Planning, Access, Care and Treatment) provider requirements for maintaining records.

Record Keeping

The Family PACT Program defers to Medi-Cal regulations for keeping and maintaining medical records. Refer to the *Provider Regulations* section in the Part 1 Medi-Cal manual.

The Family PACT Program has additional guidelines for record keeping that include, but are not limited to, the following.

Client Eligibility Certification (CEC) Form

The provider must maintain the Client Eligibility Certification (CEC) form (DHS 4461) in the medical record for each applicant or client, including those found ineligible, for a period of at least four years. See the *Family PACT: Client Eligibility Certification (CEC) Form Completion [familypact7]* section in this manual.

Sterilization Consent Form

The provider must maintain the completed and signed sterilization *Consent Form* (PM 284) in the client's chart as a permanent part of the medical record. For information about completing this form see the *Family PACT: Sterilization Consent Form [familypact12]* section in this manual.

The enrolled Family PACT provider must make the *Consent Form* available to any associated referred-to providers and facilities. Refer to the *Family PACT: Enrolled Provider Responsibilities and Other Provider Participation [familypact3]* section in this manual.

Administrative Practices

To participate in the Family PACT Program, providers must maintain legible copies of all initial and updated applications and initial and updated practitioner agreements. Refer to the *Family PACT: Provider Enrollment [familypact2]* section in this manual.

Providers must maintain within the personnel files of licensed and non-licensed staff, documentation of education and counseling training.

Transfer of Client Records: No Charge

Family PACT clients must not be charged for exchange or transfer of medical record information.

Medical Record Documentation

The *Family PACT Standards* require medical documentation to support services billed for reimbursement. The clinical rationale for providing, ordering or deferring services for client assessment, diagnosis, treatment and follow-up also is required. Additionally, documentation must reflect the scope of Education and Counseling (E & C) services, including individual client assessment. All medical record entries must be legible and the clinician clearly identifiable. Refer to the *Family PACT: Standards [familypact9]* and *Family PACT: Education and Counseling Services Overview [familypact14]* sections in this manual.